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Clinical Case Studies

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FOREWORD

The object of these studies is to afford practice in the formulation of a diagnosis on the basis of the history and physical findings, together with such technical procedures, X-ray studies, and opinions of specialists as may seem to be indicated. Actual case records are used, unchanged except for the deletion of identifying names and such editing as may seem advisable for the sake of brevity and clearness.

DIRECTIONS

Proceed on the basis that each case is a patient under your own care. The general history and physical findings as printed in this supplement represent what you would learn from the first visit of the patient in your office. After studying these make up your mind as to the most likely working diagnosis and put this in writing in the space provided for "Notes", this being solely for your own reconsideration in light of later information. Select the enclosed post card correspondingly numbered with the case problem you are studying and check off on the card the special procedures which you feel are definitely indicated; do not ask for everything blindly but for only such studies as you would order if this were your own private patient. Mail the card promptly to the Pittsburgh Diagnostic Clinic, making certain to show your name and address.

You will receive from the Clinic two packets for each case. In one, will be the information you requested, provided it is available. Study this material and make up your mind as to the final diagnosis, putting your opinion in writing on the page provided for "Notes". Then open the second packet which contains the final report made by the Clinic Staff, and follow-up information as to the patient's subsequent clinical course which serves as a check on the accuracy of the diagnosis.

It is particularly urged that you commit yourself in writing at every stage of the study because a comparison of the provisional with the final diagnosis will frequently prove most instructive.

GENERAL HISTORY

White Male Married Age 44 years

CHIEF COMPLAINT

Diarrhea, nervousness and loss of weight.

PRESENT ILLNESS

Onset gradually about a year ago when he began to notice a small, watery evacuation in the morning, preceded by a vague sensation of gas low down in the intestines, but no cramps. This continued without much change for perhaps two months and then last September he developed a generalized itching of the skin, not accompanied by any objective changes, there being no swelling or eruption. This itching was very severe and lasted about two weeks. After it subsided the diarrhea became much worse and since that time has been quite severe, causing from ten to fifteen small, watery evacuations every day including two or three during the night. In the past six months there has been some bright red blood in the stools, a full sensation in the rectum and considerable soreness when the bowels move. Since the onset about a year ago he has steadily lost weight totally at this time about 50 pounds. The weakness, and particularly the nervousness of which he complains, are so marked that it seems to be out of proportion to that which would be expected as the result of any debilitating effects of the diarrhea, especially since he states that his appetite has been about as usual and he continues to eat the usual amount of food. He has had great difficulty sleeping because of a sense of nervousness. There is also a rapid heart action, he says, which varies somewhat but is always more rapid than normal and accompanied by sensations of pounding. He apparently does not have any heat intolerance nor abnormal sweating.

PAST HISTORY

Seventeen years ago he was in bed five weeks with a polyarthritis, suggestive of inflammatory rheumatism. In general, he has always been quite well and active. Fifteen years ago he suffered for a short time with rather marked sensations of gas in his stomach, but this soon cleared up under ordinary medical treatment. Thirteen years ago he had a severe attack of sore throat and in the latter part of this he had a heart attack characterized by palpitation of the heart and a general sense of weakness which lasted for one day but since that time there has always been a tendency to tachycardia and nervousness. Six years ago after heavy lifting he suffered for several days with severe pain in the abdomen which was attributed to "knotting of the bowels" and this cleared up without any particular medication; during the two days of pain there was not any vomiting or obstinate constipation.

Aside from the above the past history is otherwise negative. Patient has always been active and energetic. About five years ago he was promoted to a superintendency, since when he has not had much physical exertion incident to his work but has routinely played golf about once a week.

Habits are regular as to hours of eating and sleeping; has never used tobacco. Alcohol—practically never.

Venereal history—negative.

Marital history—married; wife is living and well; two children ages 19 and 10, living and well.

Family history—negative.

PHYSICAL EXAMINATION

GENERAL

Height 69 inches Weight 154 pounds Temperature 100°

Patient is pale, slightly yellowish tint and has evidently lost markedly in weight, there being an appearance suggestive of true cachexia. There is slight but definite constant dyspnea not much worse during mild exertion; there is no cyanosis and no true jaundice.

HEAD AND NECK

Ears—negative. Eyes—pupils are dilated, equal, react normally, associated movements of the eyeballs are normal; there is no exophthalmus. Slight brownish tint to the sclerae. Mouth —teeth are rather poorly preserved and there is marked pyorrhea. Throat—not injected, tonsils are deep, ragged, but no infected crypts are seen. Glands—no general enlargement. Thyroid—not enlarged.

THORAX

Lungs are clear throughout.

Heart—moderately enlarged down and to the left, point of maximal impulse being in sixth interspace, just in mammillary line. The rate is 150, regular in force and rhythm (subsequent examinations pulse rate varied from 80 to 100). At the apex the impulse is circumscribed, sharp and thrusting, and is preceded by short, definite presystolic thrill. On auscultation at the apex the first sound is very loud, snapping and is preceded by a presystolic rumble but no systolic murmur can be heard. Over the base of the heart sounds are rather impure but there are no murmurs; no pericardial friction can be heard. The aortic second is less than pulmonic second. Pulse—150 (later, 80 to 90),

regular in force and rhythm; no abnormal thickening of vessel wall.

ABDOMEN

No masses or areas of tenderness; spleen is not felt; liver dullness one finger's breadth below the costal margin, but liver edge cannot be palpated. No abnormal peristalsis.

EXTREMITIES

No edema; reflexes are normal; slight but definite fairly coarse tremor of the fingers.

BLOOD PRESSURE

Systolic, 165.
Diastolic, 90.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination.

MY REVISED DIAGNOSIS

Taking into consideration reports on Special Studies.

GENERAL HISTORY

White Male Married Age 38 years

CHIEF COMPLAINT

Recurring, sharp, cramp-like pains in the upper left abdomen. Dizziness, weakness, and paleness in the last five days.

PRESENT ILLNESS

This patient's symptoms fall into two definite, rather sharply demarcated groups: First, the sharp, cramp-like pains in the left upper abdomen, behind the lower costal margin which have been present for the past month; and, second, paleness, weakness, and dizziness on exertion which developed rather abruptly last Sunday, five days ago.

The cramp-like pains came on about a month ago, at first being rather infrequent and limited mostly to the time of day when he would arrive home from his school work, and preceding the eating of supper, although he would notice very transient, similar pains, occasionally in the daytime. The pain was sharp and lancinating in character and usually the ones in the evening preceding supper would last for about a half hour and compel him to lie down until they would cease. These pains were not associated with any sensations of gas, eructations of sour material, or nausea; they gradually became more frequent and more severe so that last week he would have two or three in the daytime, several in the evening, and would often awaken in the middle of the night with a similar pain, lasting some times as long as an hour, during which time the pain was constant, very severe, localized in the left upper abdomen behind the lower costal margin, radiating out to the left and up behind the sternum. He would get up and walk about, stooped over while walking, or move about in a chair or on the bed, holding onto the affected side in the attempt to get some relief. It may be

of significance that he seemed to want to move about while the pain is intense. During all this there was no tendency to vomit and he states definitely that there was no paleness, weakness, or dizziness. Last Sunday, five days ago, he suddenly became noticeably pale, weak, and dizzy; this was so marked on Monday that he almost fainted while at his work in school. The blood pressure that evening was 120, whereas it had been 170 the preceding week. The next day (three days ago) it was 110, but has gone up to 120 as his weakness becomes less marked. For the past three days he has been at home at rest and he believes the paleness is no more marked, and the weakness and dizziness are perhaps slightly improved. Yesterday and last night he had numerous attacks of cramp-like pains, the last one being at three A.M. He has been on a liquid diet, but the appetite has been good and he has had no nausea.

His stools have been black since last Sunday. This morning he vomited for the first time, this probably being due to the taking of magnesium sulphate, followed by an egg nog. The vomitus did not contain blood. So far today he has had no attacks of pain and he states that he feels a distinct improvement.

Probably in direct relation to the present symptoms is a short attack of similar cramp-like pains last April (nine months ago); after a few days in bed they completely subsided; at that time he did not have any paleness or weakness.

PAST HISTORY

Negative except for an attack of "grippe" seventeen years ago; tonsillectomy four years ago. Otherwise, he has always been extremely robust, active and energetic. He played football while in college and at this time he weighed 185. Since leaving college he has gradually gained weight up to an average of 245.

Habits are regular as to hours of eating and sleeping. He does not use tobacco or alcohol.

Venereal history—negative.

Marital history—married; wife pregnant once, baby died about an hour after full term birth.

Family history—entirely negative.

PHYSICAL EXAMINATION

GENERAL

Height 73 inches Weight 242½ pounds Temperature 100.5°

Patient is large framed, very muscular and moderately obese; he is quite pale and there is a slight lemon-yellow tint to the skin; no cyanosis or jaundice. No signs of undue introspection or neurotic tendencies.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally, associated movements normal. Mouth—tongue coated, otherwise normal. Throat—not injected, tonsils thoroughly removed. Teeth are well preserved, gums are clean. Glands—no general enlargement. Thyroid—not enlarged.

THORAX

Lungs are clear throughout.

Heart—point of maximal impulse in fifth interspace, just in mammillary line; rate is 120, regular in force and rhythm; sounds are rather soft but are otherwise normal, no murmurs are heard. Pulse—120, regular, no abnormal thickening of vessel wall.

ABDOMEN

No masses or areas of tenderness, spleen is not felt; liver to costal margin, edge not felt. No abnormal peristalsis, no muscle resistance in the upper abdomen. On auscultation over the left costal margin where the patient states he believes he can feel some abnormal sensation when he takes a deep breath, one does get an occasional deep gurgling as though the movement of the diaphragm might be squeezing some liquid through a narrow orifice. However, this gurgling is not accompanied by any sensation of pain.

EXTREMITIES

No edema; reflexes are all normal; no tremor.

BLOOD PRESSURE

Systolic, 122.
Diastolic, 75.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination.

MY REVISED DIAGNOSIS

Taking into consideration reports on Special Studies.